Comparison of Benefits: Medicare versus Vermont Medicaid

Revised February, 2012

BENEFIT	VT MEDICAID	VT MEDICARE
Alternative Therapies (i.e., Acupuncture, Biofeedback, Holistic Medicine)	Not covered.	Not covered.
Ambulatory Surgical Centers	Covered.	Covers services given in an Ambulatory Surgical Center for a covered surgical procedure
Anesthesia	Covered.	Covered (Part A: Inpatient, Part B: Outpatient)
Blood	Whole blood is provided without cost through the Red Cross Blood Program. Costs of administering or transfusing the blood are covered as an inpatient hospital service or physician's service.	Does not cover the first three pints of blood under Part A and Part B combined in a calendar year.
Blood Tests	Inpatient diagnostic tests given to determine the nature and severity of an illness are covered. Laboratory and radiologic services may be subject to limitations and/or prior authorizations. Outpatient diagnostic services are covered only when services are specifically ordered by the patient's physician and they are reasonable and necessary for the diagnosis or treatment of the patient's illness or injury.	Covers blood tests when the tests are necessary to diagnose and evaluate diseases of the blood, but only when the person has a disease of the blood or is suspected of having a disease of the blood, and a blood test will confirm the disease. Examples of blood tests and counts, but are not limited to blood glucose testing to diagnose hypoglycemia, hyperglycemia or aid in the control of diabetes mellitus: testing for fever, leukemia, infections or inflammatory process; etc.
Bone Mass Measurement	Inpatient diagnostic tests given to determine the nature and severity of an illness are covered. Laboratory and radiologic services may be subject to limitations and/or prior authorizations. Outpatient diagnostic services are covered only when services are specifically ordered by the patient's physician and they are reasonable and necessary for the diagnosis or treatment of the patient's illness or injury.	Covered if medically necessary for certain people whose doctors say they are at risk for osteoporosis, and have one of the medical conditions listed below: • A woman whose doctor or health care provider says she is estrogen-deficient and at risk for osteoporosis, based on her medical history and other findings • A person with vertebral abnormalities as demonstrated by an X-ray • A person receiving steroid treatments • A person with hyperparathyroidism • A person taking an osteoporosis drug Covered once every 24 months (more often if medically necessary).

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Cancer Screenings: Women	Inpatient diagnostic tests given to determine the nature and severity of an illness are covered. Laboratory and radiologic services may be subject to limitations and/or prior authorizations. Outpatient diagnostic services are covered only when services are specifically ordered by the patient's physician and they are reasonable and necessary for the diagnosis or treatment of the patient's illness or injury.	Covers Pap tests and pelvic exams to check for cervical and vaginal cancers; covers a clinical breast exam to check for breast cancer as part of the pelvic exam. These screening tests are covered once every 24 months, or once every 12 months for women at high risk, and for women of child-bearing age who have had an exam that indicated cancer or other abnormalities in the past 3 years.
Cancer Screenings: Colorectal	Inpatient diagnostic tests given to determine the nature and severity of an illness are covered. Laboratory and radiologic services may be subject to limitations and/or prior authorizations. Outpatient diagnostic services are covered only when services are specifically ordered by the patient's physician and they are reasonable and necessary for the diagnosis or treatment of the patient's illness or injury.	Covers all people age 50 and older but there is no minimum age for a colonoscopy. Barium Enema: Covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk. Colonoscopy: Covered every two years for people at high risk for colorectal cancer, and every 10 years for people not at high risk. Fecal Occult Blood Test (FOBT): Covered for people age 50 or older once every 12 months. Flexible Sigmoidoscopy: Covered once every four years for people age 50 or older.
Cancer Screening: Prostate	Inpatient diagnostic tests given to determine the nature and severity of an illness are covered. Laboratory and radiologic services may be subject to limitations and/or prior authorizations. Outpatient diagnostic services are covered only when services are specifically ordered by the patient's physician and they are reasonable and necessary for the diagnosis or treatment of the patient's illness or injury.	Covers a screening digital rectal exam and a screening prostate specific antigen blood test once every 12 months for males age 50 and older.
Cardiac Rehabilitation Program	Covered.	Covers comprehensive programs that include exercise, education, and counseling for patients whose doctor referred them and who have had a heart attack in the last 12 months; coronary bypass surgery; stable angina pectoris; heart valve repair/replacement; angioplasty or coronary stenting, and/or a heart or heart-lung transplant.

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Cardiovascular Screening	Covered.	Covers screening tests for cholesterol, lipid, and triglyceride levels every five years.
Chemotherapy	Covered in all settings.	Covered for patients who are hospital A or B inpatients, outpatients, or patients in a doctor's office or freestanding clinics.
Chiropractic Services	Covers spinal manipulations only. Prior authorization for more than 10 visits per calendar year and for all children under 12. Does not cover x-rays ordered solely for the purpose of demonstrating a subluxation of the spine.	Covers manipulation of the spine if medically necessary to correct a subluxation (when one or more of the bones of your spine moves out of position) when provided by chiropractors or other qualified providers. X-rays or physical therapy provided by chiropractors are not covered.
Clinical Trials	Not Covered.	Covers routine costs, like doctor visits and tests, if you take part in a qualifying clinical trial. In most cases, does not pay for the experimental item being investigated.
Cosmetic Surgery	Cosmetic surgery for any surgical procedure for improving appearance is not covered, except when required for the prompt repair of accidental injury or the improvement of the functioning of a malformed body member. For example, the exclusion does not apply (and payment would be made) for surgery in connection with treatment of severe burns or repair of the face following an auto accident or for surgery for therapeutic purposes that coincidentally serves some cosmetic purpose. In questionable cases, authorization prior to performing surgery should be requested from OVHA.	Not covered unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Does cover breast reconstruction due to a mastectomy because of breast cancer.
Custodial Care	Covered through Home Health Agency, Nursing Home and Personal Assistance programs.	Not covered when that is the only kind of care needed. Care is considered custodial when it is for the purpose of helping with activities of daily living or meeting personal needs and can be done safely and reasonably by people without professional skills or training (e.g., help getting in and out of bed, bathing, using the bathroom, eating, and taking medicine).

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Dental	Covers routine dental care with annual maximum of $495. Emergency dental care covered through GA dental voucher. Dentures are not covered. Inpatient dental surgery is covered as a medical procedure.	Does not cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions or dentures. Does not cover dental plates (dentures) or other dental devices. Part A will pay for certain dental services received in the hospital, and for hospital stays if emergency or complicated dental procedures are needed, even when the dental care itself is not covered.
Diabetic Screening and Services	Inpatient diagnostic tests given to determine the nature and severity of an illness are covered. Laboratory and radiologic services may be subject to limitations and/or prior authorizations. Outpatient diagnostic services are covered only when services are specifically ordered by the patient's physician and they are reasonable and necessary for the diagnosis or treatment of the patient's illness or injury. Covers one diabetic education course per lifetime provided by a hospital-sponsored outpatient program, in addition to 12 diabetic counseling sessions per calendar year provided by a certified diabetic educator. Covers one membership in the American Diabetes Association (ADA) per lifetime.	Diabetes Self-Management Training: Covers up to ten hours of initial diabetes self-management training, and an additional two hours of follow-up training each year if: it is provided in a group of 2 to 20 people; it lasts for at least 30 minutes; it takes place in a calendar year following the year you got your initial training, and it is ordered by a doctor or a qualified non-physician practitioner as part of the care plan. Yearly Eye Exam: Covers yearly eye exams for diabetic retinopathy. Foot Exam: A foot exam is covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations, as long as you haven't seen a foot care professional for another reason between visits. Glaucoma Screening: Covers glaucoma screening every 12 months for people with diabetes or a family history of glaucoma, African Americans age 50 and older, or Hispanics age 65 and older. Diabetes Screening (Fasting Plasma Glucose Test): Covers tests to check for diabetes if you have any of the following risk factors: high blood pressure, dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity, or a history of high blood sugar. Medicare also covers these tests if you have two or more of the following characteristics: age 65 or older; overweight; family history of diabetes (parents, brothers, sisters); or a history of gestational diabetes (diabetes during pregnancy) or delivery of a baby weighing more than 9 pounds.

BENEFIT	VT MEDICAID	VT MEDICARE
Diabetic Supplies	Covers diabetic diagnostics and daily care supplies; diabetic equipment and supplies; treatment of foot lesions resulting from infection or diabetic ulcers; molded orthopedic shoes when prescribed for diabetes (limited to two pairs per adult beneficiary per calendar year).	Covers some diabetes supplies, including blood glucose test strips, blood glucose monitor, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors. External insulin pump and insulin are covered as durable medical equipment. Insulin and certain medical supplies used to inject insulin are covered under Medicare Part D.
Dialysis Services	Covered.	Covers inpatient kidney dialysis treatments if admitted to a hospital for special care and have ESRD; outpatient maintenance dialysis treatments (when provided in any Medicare-approved facility); certain home support services (may include visits by trained dialysis workers to check on home dialysis, to help in emergencies when needed, and check dialysis equipment and water supply); and self-dialysis training (for the patient and for the person helping the patient with home dialysis).
Doctor's Office Visits	Office visits - up to five visits per month; Home visits - up to five visits per month; Nursing facility visits - up to one visit/month; Hospital visits - up to one visit per day for acute care, or after denial for acute care by utilization review, up to one visit per month for sub-acute care. Visits in excess of these can be reimbursed if there is a significant change in the health status of the patient that requires more frequent visits. Payment for concurrent care is limited to one practitioner unless it can be demonstrated that such care is part of a coordinated treatment plan. Payment for surgery services includes normal postoperative care for 30 days after surgery.	Covers medically necessary services provided by a doctor in his or her office, in a hospital, in a skilled nursing facility, in home, or any other location. Routine gynecological (GYN) exams are not covered.

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Doctor's Office Visits - Physical Exams (Routine)	Routine physical exams, diagnostic services, immunizations, and certain injectable drugs are covered.	Medicare will cover a one-time routine visit known as "Welcome to Medicare" preventive visit. 12 months after being enrolled in Medicare a yearly "Wellness" visit is covered. You do not need to have the Welcome to Medicare preventive visit done first.
Durable Medical Equipment (DME) and Supplies	Items of durable medical equipment that have been pre-approved for coverage are limited to: • Alternating pressure pumps and mattresses, gel and egg crate mattresses, and decubitus care pads; • Ambulatory uterine monitoring devices; • Apnea monitors and related supplies and services; • Bathtub chairs and seats, including shower chairs and transfer benches; • Beds (hospital frame and mattress) and bed accessories for severe medical conditions, e.g., cardiac disease, chronic obstructive lung disease, spinal cord injuries including quadriplegia (Note: Craftomatic beds, oscillating/lounge beds, bed boards, ordinary mattresses, beds larger than single occupancy, tables and other bed accessories are not covered.); • Biosteogenic stimulators; • Blood glucose monitors; • Blood pressure cuffs/machines (including stethoscopes) when prescribed for patients who require frequent monitoring for a specific disease and when used as an alternative to home health nursing visits; • Rental of electric breast pumps and supplies for mothers of premature or critically-ill newborns; • Canes, crutches, walkers; • Circulatory aids; • Commodes (including bed pans, urinal pans and raised toilet seats) when the beneficiary is unable to access typical bathroom facilities; • Continuous passive motion devices (CPM) for homebound beneficiaries who have received total knee replacements; • Cushions and invalid rings; • Diabetic equipment and diagnostics and daily care supplies; • Digital electronic pacemaker monitor; • External infusion pumps;	Covers durable medical equipment (DME) prescribed by a doctor for use in the home, if stringent medical criteria are met, including, but not limited to: • Air-fluidized beds • Artificial limbs and eyes • Blood glucose monitors • Braces (arm, leg, back, and neck) • Breast prostheses (external) • Canes (white canes for the blind are not covered) • Cervical Traction Devices • Commode chairs • Continuous Positive Airway Pressure (CPAP) Device • Crutches • Dialysis Equipment and Supplies • Enteral and parenteral nutrients, supplies and equipment Home oxygen equipment and supplies • High Frequency Chest Wall Oscillation Devices • Hospital beds • Infusion pumps (and some medicines used in infusion pumps if reasonable and necessary) • Lymphedema pumps, orpneumatic compression devices • Nebulizers (and some medicines used in nebulizers if reasonable and necessary) • Negative Pressure Wound Therapy Pumps • Ostomy supplies • Oxygen Therapy equipment and supplies • Patient lifts (to lift patient from bed or wheelchair by manual or power operation) • Pressure-reducing Support Surfaces • Prosthetic devices needed to replace an internal body part or function • Speech Generating Devices

BENEFIT	VT MEDICAID	VT MEDICARE
	• Heating pads/lights; • Lifts (hydraulic or electric, including one sling), if safe transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person; • Oxygen systems; • Portable sitz baths; • Protective helmets when the beneficiary is prone to falling (e.g. seizures, ataxia); • Repair of durable medical equipment including parts and labor; • Respiratory/tracheostomy equipment, care supplies and services; • Seat lift chairs when the beneficiary is unable to achieve a standing position without assistance; • Suction equipment; • Stethoscopes when acquisition is less costly than an alternative covered item or service; • TENS/EMS units; • Traction equipment; • Vaporizers; and • Wheelchairs • Special needs infant feeder bottles • Car seats for children with special health needs who meet specific clinical criteria • Other medical supplies, necessary for the care and treatment of an eligible person and suitable for use in the home, including: - adhesive tape and removers; - antiseptics; - briefs, diapers and underpads; - catheters and catheter supplies; - cotton and cotton-like products; - eye care and gauze pads and rolls; - gloves; - irrigation supplies; - low protein modified food products for treatment of an inherited metabolic disease, - lubricating jelly; - ostomy care supplies (including adhesives, irrigation supplies, bags and miscellaneous); and - secondary dressings.	• Spinal Orthoses • Suction pumps • Surgical dressings surgical to treat a wound caused by surgery or pressures sores/ulcers • Traction equipment • Urological supplies • Walkers • Wheelchairs Does not cover orthopedic shoes unless they are a necessary part of the leg brace and the cost is included in the charge for the brace. Does not cover common medical supplies like bandages, gauze, briefs, diapers or underpads.

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Emergency Room Services	Covered, but not in foreign countries. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition. "Emergency medical condition" means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possess an average knowledge of health and medicine, to result in: a. placing the member's physical or mental health in serious jeopardy; or b. serious impairment to bodily functions; or c. serious dysfunction of any bodily organ or part.	Covered, but not covered in foreign countries, except in some instances in Canada and Mexico.
Eye Care	Eyeglasses and vision care services that have been pre-approved for coverage are limited to: • one comprehensive visual analysis and one interim eye exam within a two-year period; • diagnostic visits and tests; • dispensing fees (all dispensing fees for beneficiaries age 21and older are suspended indefinitely); • a prescription for frames and lenses every two years (all frames and lenses for beneficiaries age 21 and older are suspended indefinitely); • contact and special lenses, when medically necessary and with prior approval (all contact and special lenses for beneficiaries age 21 and older are suspended indefinitely); and • other aids to vision, such as closed circuit television, when the beneficiary is legally blind and when providing the aid to vision would foster independence by improving at least one activity of daily living (ADL or IADL).	Does not cover routine eye exams or eye refractions. Generally, does not cover eyeglasses or contact lenses. However, following cataract surgery with an intraocular lens, Medicare helps pay for cataract glasses, contact lenses, or intraocular lenses provided by an ophthalmologist. Services provided by an optometrist may be covered. Covers glaucoma screening, once every 12 months for people with Medicare at high risk for glaucoma (i.e., people with diabetes, a family history of glaucoma, or African-Americans who are age 50 and older). Covers ocular photodynamic therapy with verteporfin treatment for some patients with age-related macular degeneration. Eye prostheses are covered for patients with absence or shrinkage of an eye due to birth defect, trauma or surgical removal.

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Foot Care	Covered podiatry services performed by a licensed podiatrist or chiropodist within the scope of his license or by any other physician are limited to non-routine foot care, such as surgical removal of ingrown toenails, treatment of foot lesions resulting from infection or diabetic ulcers, and similar Medicare covered services. The following routine foot care services are excluded, regardless of who performs them: • Treatment of flat foot conditions and supportive devices used in such treatment; • Treatment of subluxations of the foot (structural misalignments of the joints of the feet) not requiring surgical procedures (i.e., treatment by strapping, electrical therapy, manipulations, massage, etc.); and • Curring or removal of corns or calluses, trimming of nails and preventive or hygienic care of the feet. The fact that an individual is unable, due to physical disability, to perform routine foot care services for himself does not change the character of the services and make them "non-routine".	Does not cover routine foot care. However, foot care services are covered for a medical condition affecting circulation of the legs or feet and for medically necessary treatment of injuries or diseases of the foot (such as hammer toe, bunion deformities and heel spurs).
Health and Wellness Screening	Covered.	Not covered.
Hearing Exams and Hearing Aids	Audiology services that have been pre-approved for coverage: • Audiologic examinations; • Hearing screening; • Hearing assessments; • Diagnostic tests for hearing loss; • Analog hearing aids, plus their repair or replacement for beneficiaries of any age; • Digital hearing aids, plus their repair or replacement for beneficiaries under age 21; • Prescriptions for hearing aid batteries - six batteries per month; • Fitting/orientation/checking of hearing aids; and, • Ear molds. Unless authorized for coverage via rule 7104, nonmedical items, such as canal aids and maintenance items other than batteries, and fees associated with selection trial periods or loaners are not covered; nor are digital hearing aids for beneficiaries age 21 or older.	Does not cover routine hearing exams or hearing aids. In some cases, diagnostic hearing exams are covered by Part B.

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Home Health	Home health agency services are covered for beneficiaries of any age. Targeted case management services are limited to at-risk children ages 1-5. Home health agency services that have been pre-approved for coverage are limited to: • skilled nursing care services; • rehabilitative therapy services • home health aide services; • medical supplies, equipment and appliances suitable for use in the home; and • targeted case management. Home health care services are covered when the conditions for Medicare (Part A or Part B) payment are met or when all of the following conditions are met: A. General Conditions: For Medicaid reimbursement, there is no homebound restriction, nor is a three-day prior hospitalization required. The patient's condition may be either an episode of acute illness or injury or a chronic condition requiring home health care under a physician's order. Payment for home health services will not be made to any agency or organization that is operated primarily for the care and treatment of a mental disease. B. Requirement for a Written Plan: Items and services are ordered and furnished under a written plan, signed by the attending physician and incorporated into the agency's permanent record for the patient. C. Location Where Service is Provided: The service or item is furnished in the beneficiary's place of residence. A place of residence includes beneficiary's own dwelling; an apartment; a relative's home; a place where patients or elderly people congregate such as senior citizen or adult day center; a community care home; and a hospital or nursing home but the last two only for the purpose of an initial observation, assessment and evaluation visit. D. Coverage of Initial Visit: An initial visit by a registered nurse or appropriate therapist to observe and evaluate a beneficiary	Covers skilled nursing care and certain other in-home health care services for the treatment of an illness or injury if: 1. Your doctor decides you need medical care in your home, and makes a plan for your care at home, and 2. You need at least one of the following: intermittent (and not full time) skilled nursing care, or physical therapy or speech language pathology services, or a continued need for occupational therapy, and 3. You are homebound. This means you are normally unable to leave home and that leaving home is a major effort. When you leave home, it must be infrequent, for a short time. You may attend religious services. You may leave the house to get medical treatment, including therapeutic or psychosocial care. You can also get care in an adult day-care program that is licensed or certified by a state or accredited to furnish adult day care services in a state. Part B covers an injectable drug for osteoporosis in women who meet the criteria for the Medicare home health benefit, and who have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. Must be certified by a doctor as unable to learn, or as physically or mentally unable to give yourself the drug by injection, and that family and/or caregivers are unable or unwilling to give the drug by injection. Also covers the visit by a home health nurse to give the drug.

BENEFIT	VT MEDICAID	VT MEDICARE
	either in the hospital, nursing home or community for the purpose of determining the need for home health services is covered. If physician-ordered treatment is given during the initial visit, the two services may not be charged separately. E. Requirements Specific to Nursing Care: Nursing care services are covered when the services are related to the care of patients who are experiencing acute or chronic periods of illness and those services are: • ordered by and included in the plan of treatment established by the physician for the patient; and • required on an intermittent basis; and • reasonable and necessary to the treatment of an illness, injury or condition. F. Requirements Specific to Home Health Aide Services: Services of a home health aide are covered when assigned in accordance with a written plan of treatment established by a physician and supervised by a registered nurse or appropriate therapist. Under appropriate supervision, the home health aide may provide medical assistance, personal care, assistance in the activities of daily living such as helping the patient to bathe, to care for hair or teeth, to exercise and to retrain the patient in necessary self-help skills. In cases where home health aides are assigned to patients requiring specific therapy, the home health aide must be supervised by the appropriate therapist; however, it is not necessary in these cases to require an additional supervisory visit by the nurse to supervise the provision of personal services. During a particular visit, the home health aide may perform household chores (such as changing the bed, light cleaning, washing utensils, and assisting in food preparation) that are incidental to the visit. Supervisory visits by a registered nurse or appropriate therapist must be performed at least every 62 days, and more frequently if necessary. G. Requirements Specific to Medical Supplies: Medical supplies are covered when they are essential for enabling home health agency personnel to effectively carry out the care and treatment that has been ordered for the patient by the physician and used during the visit. These items include catheters, needles, syringes, surgical dressings, and materials used for dressings such as	

BENEFIT	VT MEDICAID	VT MEDICARE
	cotton gauze and adhesive bandages. Other medical supplies include, but are not limited to, irrigating solution, and intravenous fluids and oxygen. Certain supplies are not covered. H. Requirements Specific to Durable Medical Equipment: The rental of durable medical equipment (DME) included on the list of DME items pre-approved for coverage that the home health agency owns and is used by a patient as part of the plan of care, is covered when the conditions of coverage are met. Coverage of rental of a specific item of DME may be subject to prior authorization. The DME coverage limitations also apply to DME provided by a home health agency. I. Requirements Specific to Targeted Case Management Services: Targeted case management services are provided only to children ages one to five who are at-risk for unnecessary and avoidable medical interventions and who do not have another primary case management provider whose responsibility is to provide or coordinate the interventions included in this service. The Vermont Department of Health will review and determine how many targeted case management visits shall be authorized to at-risk children ages one to five. J. Requirements Specific to Therapy Services: Physical, occupational, and speech therapy services are covered for up to four months based on a physician's order. Provision of these services beyond this initial four-month period requires prior authorization. Therapy services must be: • directly related to an active treatment regimen designed by the physician; and • of such a level of complexity and sophistication that the judgment, knowledge, and skills • of a qualified therapist are required; and • reasonable and necessary under accepted standards of medical practice to the treatment of the patient's condition. Therapy services provided outside the home and requiring equipment that cannot be brought to the home are covered provided that the agency has met certifying standards for that service under Medicare.	

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Hospice	Hospice services to terminally ill recipients are covered in accordance with Section 1905(o) of the Social Security Act. Hospice services must be rendered by a Medicare certified hospice and be provided in accordance with Medicare regulations. Recipients of hospice care are required to sign an election of hospice care which waives all other Medicaid coverage except the services of a designated family physician, ambulance service and services unrelated to the terminal illness. Payment to enrolled hospice providers will be made at the daily rates set by Medicare for each provider. The total number of days of hospice coverage is limited to 210 days. Rates of payment and total reimbursement for hospice care will be made in accordance with Medicare reimbursement and audit principles. Medicaid will make no payment to the hospice selected by the Medicaid recipient for any services or supplies other than the hospice service. The hospice may not charge any amount to or collect any amount from the recipient or the recipient's family for a covered hospice service during the period of hospice coverage.	Covered if: • You are eligible for Medicare Part A; and • Your doctor and the hospice medical director certify that you are terminally ill and probably have less than six months to live; and • You sign a statement choosing hospice care instead of routine Medicare covered benefits for your terminal illness. (Medicare will still pay for covered services for any health problems that are not related to your terminal illness). Does not cover room and board if hospice care is provided in home, in a nursing home or a hospice residential facility. In certain cases, depending on the level of service provided, the costs for room and board are included in Medicare's payment (for example, when a hospice patient is admitted to a hospital or skilled nursing facility for the inpatient or respite level of care). Rural Hospice Care: Allows a nurse practioner to serve as an attending physician for a patient who elects the hospice benefit, but they are prohibited from certifying a terminal diagnosis. Respite Care: If you are receiving covered hospice care, inpatient respite care is covered in a hospice facility, hospital or nursing home, up to 5 days each time you get respite care. There is no limit to the number of times you can get respite care.
Hospital Inpatient Care	Covered inpatient general hospital services include the following: A. Medically necessary care in a semi-private (2-4 beds) room; B. Private room if certified medically necessary by a physician to avoid jeopardizing the health of the patient or to protect the health and safety of other patients. (No payment will be made for any portion of the room charge when the recipient requests and is provided with a private room for his or her personal comfort; i.e., when the private room is not medically necessary; C. Use of intensive care unit when medically necessary; D. Nursing and related services (except private duty nurses); E. Use of hospital facilities, such as operating and recovery room, X-ray, laboratory, etc.; F. Use of supplies, appliances and equipment, such as splints, casts, wheelchairs, crutches, etc.;	Covered if all of the following are true: • A doctor says you need inpatient hospital care for treatment of your illness or injury. • You need the kind of care that can be given only in a hospital. • The Utilization Review Committee of the hospital does not disapprove your stay while you are in the hospital. • A Quality Improvement Organization or an intermediary does not disapprove your stay after the bill is submitted. Covered hospital services include: A semiprivate room, meals, general nursing, and other hospital services and supplies. Includes care in critical access hospitals and inpatient mental health care. Does not include private duty nursing or a television or telephone in your room. Does not include a private room, unless medically

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	G. Blood transfusions; H. Therapeutic services, such as X-ray or radium treatment; and I. Drugs furnished by the hospital as part of inpatient care and treatment, including drugs furnished in limited supply to permit or facilitate discharge from a hospital to meet the patient's requirements until a continuing supply can be obtained; J. Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy services; K. Diagnostic services, such as blood tests, electrocardiograms, etc., but only when these services are specifically ordered by the patient's physician and they are reasonable and necessary for the diagnosis or treatment of the patient's illness or injury. The following inpatient services are excluded: • Private room at patient's request for his personal comfort; • Personal comfort items such as telephone, radio or television in hospital room; • Private duty nurses; • Inpatient hospital services directly related to experimental treatment and other non-covered procedures.	necessary. Co- pays for each benefit period (2011): Days 1 - 60: an initial deductible of $1,132 Days 61 - 90: $283 each day Days 91 - 150: $566 each day 150 days: All costs A benefit period begins the day of hospital admission (or under special circumstances, a skilled nursing facility), and ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. Lifetime reserve days give an extra 60 days of inpatient coverage when you are in a hospital for more than 90 days: the 60 reserve days can be used only once during a lifetime.
Hospital Outpatient Services	"Outpatient hospital services" are defined as those covered items and services indicated below when furnished in an institution meeting the hospital services provider criteria (rule 7201), by or under the direction of a physician, to an eligible beneficiary who is not expected to occupy a bed overnight in the institution furnishing the service. Covered items and services include: • Use of facilities in connection with accidental injury or minor surgery. Treatment of accidental injury must be provided within 72 hours of the accident. • Diagnostic tests given to determine the nature and severity of an illness; e.g., x-rays, pulmonary function tests, electrocardiograms, blood tests, urinalysis and kidney function tests. Laboratory and radiologic services may be subject to limitations and/or prior authorizations as specified in Rule 7405.	Covers medically necessary services for diagnosis or treatment of an illness or injury. Covered services include: • Services in an emergency room or outpatient clinic, including same-day surgery; • Laboratory tests billed by the hospital; • Mental health care in a partial hospitalization program, if a physician certifies that inpatient treatment would be required without it; • X-rays and other radiology services billed by the hospital; • Medical supplies such as splints and casts; and • Drugs and biologicals that you cannot give yourself.

BENEFIT	VT MEDICAID	VT MEDICARE
	• Diabetic counseling or education services; one diabetic education course per beneficiary per lifetime provided by a hospital-sponsored outpatient program, in addition to 12 diabetic counseling sessions per calendar year provided by a certified diabetic educator. Additional counseling sessions with a diabetic educator may be covered with prior authorization. Medicaid also covers one membership in the American Diabetes Association (ADA) per lifetime. • Rehabilitative therapies (physical, occupational, and speech) • Inhalation therapy Use of the emergency room at any time is limited to instances of emergency medical conditions.	
Immunizations	Covered.	Covers flu, pneumonia, and hepatitis vaccinations. Other types of vaccinations and immunizations are typically not covered.
Immunosuppressive Drugs	Covered.	Covers prescription drugs used in immunosuppressive therapy when: • the drugs are prescribed following a kidney, heart, liver, bone marrow/stem cell, lung, heart/lung transplant, whole organ pancreas transplant performed at the same time as or following a kidney transplant because of diabetic nephropathy or intestinal transplant; and, • the transplant met Medicare coverage criteria in effect at the time; and, • the patient was enrolled in Medicare Part A at the time of the transplant and is enrolled in Medicare Part B at the time that the drugs are dispensed; and, • the drugs are used to prevent or treat rejection of an organ transplant in the particular patient; and, • the drugs are provided on or after the date of discharge from the hospital following a covered organ transplant.

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Lab Services	Covered laboratory and radiology services include the following: • Microbiological, serological, hematological and pathological examinations; and • Diagnostic and therapeutic imaging services; and • Electro-encephalograms, electrocardiograms, basal metabolism readings, respiratory and cardiac evaluations. Coverage is extended to independent laboratories and radiological services approved for Medicare participation for services provided under the direction of a physician and certification that the services are medically necessary. When the place of service is "hospital inpatient", coverage for the technical component is included in the per diem hospital reimbursement. When the place of service is "hospital outpatient", coverage is included in the hospital reimbursement on the outpatient claim form for the technical component. Reimbursement for the professional component is made only to a physician. Total procedure codes may be used for anatomic pathology services performed by a laboratory outside the hospital in which the beneficiary is an inpatient or for an independent laboratory performing tests for registered inpatients. Laboratory services for urine drug testing are limited to eight (8) tests per calendar month for beneficiaries age 21 and older. This limitation applies to tests provided by professionals, independent labs and hospital labs for outpatients.	Covers medically-necessary diagnostic lab services that are ordered by the treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory enrolled in Medicare
Mammograms	Covered.	Covered every 12 months for women age 40 and older, and covers one baseline mammogram for women between ages 35 and 39.

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Mental Health Care	The following services are covered: • mental health and chemical dependency services provided by a community mental health center (see below); this includes case management and community support services in addition to other covered activities • outpatient psychotherapy provided by a doctor, PhD and MA clinical psychologist, clinical social worker, clinical nurse specialist, physician assistant, nurse practitioner, or licensed mental health counselor Diagnostic tests performed by a psychologist practicing independently of an institution, agency, or physician's office are covered. Psychotherapy or diagnostic tests provided by a psychologist practicing independently to an inpatient or outpatient of general hospital or mental hospital or for a client in a community mental health clinic also are covered. Community Mental Health Centers (Clinics): For policies, amount, duration and scope of benefits, and reimbursement rates, see the Department of Mental Health regulations #8l-A20. The Department of Mental Health is also responsible for determining provider eligibility as a Community Mental Health Center.	Inpatient Mental Health Care: Covered; can be provided in a general hospital or in a specialty psychiatric hospital that only cares for people with mental health problems; if provided in a specialty psychiatric hospital, only pays for a total (lifetime limit) of 190 days of inpatient care. Outpatient Mental Health Care: Covered if provided by a doctor, PhD clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office setting, clinic, or hospital outpatient department. 40% co-pay. Partial Hospitalization: Covered if a doctor says that you would otherwise need inpatient treatment. Case management and community support services are not Medicare reimbursable.
Non-Physician Health Care Provider Services	Medicaid payment for covered services is limited to physicians and other specified practitioners licensed by the appropriate licensing agency of the State.	Covers the services of specially qualified non-physician practitioners such as clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetists, speech-language pathologists, and certified nurse midwives, as allowed by state and local law for medically necessary services.
Nursing Home Care	Covered. *(See Home Health Description)*	Only covers skilled care given in a certified skilled nursing facility (SNF). You must meet certain conditions and coverage is limited. Does not cover custodial care provided in a nursing home.

BENEFIT	VT MEDICAID	VT MEDICARE
Nutrition Therapy Services	Covered.	Covers medical nutrition therapy if you have diabetes or kidney disease, and your doctor refers you for this service. These services can be given by a registered dietitian or Medicare-approved nutrition professional and include a nutritional assessment, and counseling to help manage diabetes or kidney disease. Covers 3 hours of one-on-one counseling services the first year, and 2 hours each year after that. If the condition, treatment, or diagnosis changes, more hours may be obtained with a doctor's referral.
Occupational, Physical and Speech Therapy	The following service limitations/ prior authorization (PA) requirements are not applicable when Medicare is the primary payer. A. Rehabilitative Therapy Services for Beneficiaries Age 21 and Older: Thirty (30) therapy visits per calendar year are covered and include any combination of physical therapy, occupational therapy and speech/language therapy. PA beyond 30 therapy visits in a calendar year will only be granted to beneficiaries with the following diagnoses, and only if the beneficiary meets the criteria found in Rule 7317: • Spinal Cord Injury • Traumatic Brain Injury • Stroke • Amputation • Severe Burn B. Rehabilitative Therapy Services for Beneficiaries Under Age 21: Services are covered for up to four months based on a physician's order. Provision of therapy services beyond the initial four-month period is subject to prior authorization review. Rehabilitative therapy services provided by a home health agency are covered for up to four months based on a physician's order, for beneficiaries of any age. Provision of therapy services beyond the initial four-month period is subject to PA review.	Covers medically necessary outpatient physical and occupational therapy and speech-language pathology services when: • the doctor or therapist sets up the plan of treatment, and • the doctor periodically reviews the plan to see how long therapy is needed. Services can be provided by a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency, or public health agency. Physical and occupational therapy can be provided in private practice office or in home; speech therapy cannot. The benefit for outpatient physical therapy and speech-language pathology services (combined) is limited to $1840 per year. There is a separate yearly benefit limit of $1840 for outpatient occupational therapy. There is no cap if services are provided in a hospital outpatient therapy department. People who occupy a Medicare-certified bed in a skilled nursing facility are limited to the cap amounts and cannot receive additional covered outpatient hospital therapy while in the certified bed.

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Prescription Drugs	Payment may be made for any preparation, except those unfavorably evaluated, either included or approved for inclusion in the latest edition of official drug compendia: the U. S. Pharmacopoeia, the National Formulary, the U. S. Homeopathic Pharmacopoeia, AMA Drug Evaluations, or Accepted Dental Therapeutics. These consist of both "legend" drugs, for which a prescription is required by State or Federal law, and "over-the-counter" medicinals, normally purchasable without a prescription. Physicians and pharmacists are required to conform to Act l27 (l8-VSA-Chapter 9l), otherwise known as the Generic Drug Bill. In those cases where the Generic Drug Bill permits substitution, only the lowest priced equivalent in stock at the pharmacy shall be considered medically necessary. If, in accordance with Act l27, the patient does not wish to accept substitution, Medicaid will not pay for the prescription. Coverage of over-the-counter and prescription smoking cessation products is provided to beneficiaries of any age with a limit of two treatment regimens per beneficiary, per calendar year. Contraceptive drugs, supplies, and devices are covered when provided on a physician's order. Birth control pills may be dispensed in a quantity not to exceed a 92-day supply.	Part B covers a limited number of outpatient prescription drugs: • Some Antigens. • Osteoporosis Drugs. • Erythropoisis-stimulating Agents for end-stage renal disease or for anemia related to certain other conditions. • Blood Clotting Factors: If you have hemophilia, Medicare will help pay for clotting factors you give yourself by injection. • Injectable Drugs: Medicare covers most injectable drugs administered by a licensed medical practitioner, if the drug is considered reasonable and necessary for treatment. • Immunosuppressive Drugs for transplant patients • Oral Cancer Drugs if the same drug is available in injectable form. • Oral Anti-Nausea Drugs used as part of an anti-cancer chemotherapeutic regimen. • Covers some drugs used in infusion pumps and nebulizers if considered reasonable and necessary. Part D provides more comprehensive coverage. See Diabetic Supplies for information about coverage for these prescriptions.
Radiation Therapy	Covered.	Covered for patients who are hospital inpatients or outpatients, or patients in freestanding clinics
Respite Care	Home and Community-Based Services include long-term care services provided in a home setting or an enhanced residential care setting. An individualized written service plan shall be developed for each participant. Services may include assistance with Activities of Daily Living, Instrumental Activities of Daily Living, Adult Day Service, Respite, Companion Service, Personal Emergency Response System, Home Modification/Assistive Devices, and other such services as DAIL may include (Choices for Care Regulations).	Covered if you are getting covered hospice care. You can stay in a Medicare-approved facility, such as a hospice facility, hospital or nursing home, up to 5 days each time you get respite care. There is no limit to the number of times you can get respite care.

BENEFIT	VT MEDICAID	VT MEDICARE
Skilled Nursing Facility Care	Covered. *(See Home Health Description)*	Covers certain skilled care services in a skilled nursing facility (SNF) that is needed daily on a short-term basis (up to 100 days). Skilled care is health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Examples of skilled care include changing sterile dressings and physical therapy. Care that can be given by non-professional staff is not considered skilled care. Medicare will cover skilled care only if all of the following conditions are met: 1. You have Medicare Part A and have days left in your benefit period to use. 2. You have a qualifying hospital stay. This means an inpatient hospital stay of three consecutive days or more, not including the day you leave the hospital. You must enter the SNF within a short time (generally 30 days) of leaving the hospital and require skilled services related to your hospital stay. After you leave the SNF, if you re-enter the same or another SNF within 30 days, you don't need another three-day qualifying hospital stay to get additional SNF benefits. This is also true if you stop getting skilled care while in the SNF and then start receiving skilled care again within 30 days. 3. Your doctor has decided that you need daily skilled care. It must be given by, or under the direct supervision of, skilled nursing or rehabilitation staff. If you are in the SNF for skilled rehabilitation services only, your care is considered daily care even if these therapy services are offered just 5 or 6 days a week. 4. You need these skilled services for a medical condition that: - Was treated during a qualifying 3-day hospital stay, or - Started while you were receiving Medicare-covered SNF care. For example, you are in the SNF because you had a stroke, and you develop an infection that requires I.V. antibiotics.
Smoking Cessation Counseling to quit smoking	Covers face-to-face counseling for smoking cessation for pregnant Vermont Medicaid beneficiaries with a maximum of 16 visits per calendar year. Providers who can bill Vermont Medicaid for smoking cessation counseling are physicians, nurse practitioners, licensed nurses, nurse midwives, and physician's assistants. Qualified" Tobacco Cessation Counselors are also allowed.	Covered if you haven't been diagnosed with an illness caused by tobacco use.

BENEFIT	VT MEDICAID	VT MEDICARE
Substance Abuse Treatment	The following services may be accessed by beneficiaries without a referral from their primary care provider (PCP): • mental health and chemical dependency services	Covered in an outpatient treatment center if they have agreed to participate in the Medicare program. 50% co-pay.
Surgical Services	Covered. Cosmetic surgery and expenses incurred in connection with such surgery are not covered. Cosmetic surgery encompasses any surgical procedure directed at improving appearance (including removal of tattoos), except when required for the prompt repair of accidental injury or the improvement of the functioning of a malformed body member. For example, the exclusion does not apply (and payment would be made) for surgery in connection with treatment of severe burns or repair of the face following an auto accident or for surgery for therapeutic purposes that coincidentally serves some cosmetic purpose. In questionable cases, authorization prior to performing surgery should be requested from OVHA. Experimental surgery and expenses incurred in connection with such surgery are not covered. Experimental surgery encompasses any surgical procedure not proven to be clinically efficacious by literature and experts in the field. <u>Medical and surgical services of a dentist</u>: those services furnished by a doctor of dental medicine or dental surgery if the services are services that: • if furnished by a physician, would be considered physician services; and • under Vermont law, may be furnished by either a physician or a doctor of dental medicine or surgery. These services are covered as hospital and/or physician services and subject to the applicable limitations	Covered.
Second Surgical Opinions	Covered.	Covers a second opinion before surgery. Will also help pay for a third opinion if the first and second opinions are different.

BENEFIT	VT MEDICAID	VT MEDICARE
Transplants	Organ transplantation services are covered once the procedure is no longer considered experimental or investigational. Reimbursement will be made for medically necessary health care services provided to an eligible beneficiary or a live donor and for the harvesting, preservation, and transportation of cadaver organs. May require PA and must meet Standards for Coverage.	Covers heart, lung, kidney, pancreas, intestine / multivisceral, liver, bone marrow and cornea transplants under certain conditions. Transplant coverage includes necessary tests, labs, and exams before surgery for you and the organ donor, doctor services related to the transplant, follow-up care for you and a live donor, and procurement of organs and tissues.
Transportation (Routine)	Transportation to and from necessary medical services is covered and available to eligible Medicaid recipients on a statewide basis. The following limitations on coverage apply: A. Prior authorization is required. (Exceptions may be granted in a case of a medical emergency.) B. Transportation is not otherwise available to the Medicaid recipient. C. Transportation is to and from necessary medical services. D. The medical service is generally available to and used by other members of the community or locality in which the recipient is located. A recipient's freedom of access to health care does not require Medicaid to cover transportation at unusual or exceptional cost in order to meet a recipient's personal choice of provider. E. Payment is made for the least expensive means of transportation and suitable to the medical needs of the recipient. F. Reimbursement for the service is limited to enrolled transportation providers. G. Reimbursement is subject to utilization control and review in accordance with the requirements of Title XIX. H. Any Medicaid-eligible recipient who believes that his or her request for transportation has been improperly denied may request a fair hearing.	Does not cover transportation to get routine health care.

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Transportation by Ambulance	In order for ambulance services provided to eligible Medicaid recipients to be covered, the following conditions must be met: • The vehicle and personnel must be certified for participation in Medicare; and • Other methods of transportation must be medically contra-indicated. No payment will be made when some means of transportation other than an ambulance could have been used without endangering the individual's health; and • The ambulance service must be ordered by a physician or certified as to necessity by a physician at the receiving facility; and • The patient must be transported to and accepted as an inpatient or as an emergency outpatient in an institution (i.e., a hospital or skilled nursing facility) whose locality (i.e., the service area surrounding the institution from which individuals normally come or are expected to come) encompasses the place where the transportation began and which would be expected to have the appropriate facilities for the treatment of the injury or illness involved. Coverage is also provided for transporting of an inpatient of a hospital or skilled nursing facility to his home. Prior authorization from the Office of Vermont Health Access is required to qualify for reimbursement for transportation to an out-of-state hospital. An out-of-state hospital is any hospital located outside the borders of Vermont except those listed in Vermont Medicaid rule 7201. Ambulance services are not covered if they are provided to a hospital inpatient for the purpose of transporting the patient to and from another facility for outpatient services not available at the hospital where the patient was admitted.	Not covered for doctor's office visits. Transport to a hospital or skilled nursing facility (SNF), are covered only if transportation in any other vehicle would endanger your health, and Medicare only pays for transportation to the closest appropriate facility that can provide the needed care. If person chooses to go to another facility farther away, Medicare payment is based on how much it would cost to go to the closest appropriate facility.
Urinalysis	Covered (See Outpatient Services).	Covered if the person has documented signs or symptoms of a kidney/urinary tract disorder or a condition that is known to affect the kidney/urinary tract.